

657-2941

Letter No.: 93-75

- Southern Region 1  
Training Date: September 21;  
Training Location: Los Angeles (completed)
- Bay Area Region  
Training Date: October 1;  
Training Location: San Francisco (completed)
- Valley Mountain Region  
Training Date: October 5;  
Training Location: Rocklin (completed)
- Northern Region  
Training Date: October 13;  
Training Location: Redding  
(postponed from September 28)  
2460 Breslauer Way, Cascade Room (Room 55)  
Time: 10:00 a.m. - 2:00 p.m.

ALL COUNTY WELFARE DIRECTORS  
ALL COUNTY ADMINISTRATIVE OFFICERS  
ALL COUNTY MEDI-CAL PROGRAM SPECIALISTS/LIAISONS  
Page 2

- Valley Region  
Training Date: October 21;  
Training Location: Fresno (Address to be announced)  
(postponed from September 30)  
Time: 10:00 a.m. - 2:00 p.m.
- Southern Region 2  
Training Date: October 27;  
Training Location: San Diego (Address to be announced)  
(postponed from October 13).  
Time: 10:00 a.m. - 2:00 p.m.

If your county had planned on attending one of the postponed training sessions, or your staff is unable to attend the new training scheduled for your region you may attend one of the sessions provided in another region.

At the MC 210 update training, counties will have an opportunity to review the most recent MC 210 changes, ask questions, and receive individual instruction as needed. We encourage counties to ensure the appropriate staff attend these training sessions. Please contact Tony Plescia at (916) 657-3185 or Sherilyn Walden at (916) 657-3091 to let us know which training session your county will attend and the number of staff attending that training session.

#### **FORMS PROCEDURES**

As the structure of the revised MC 210, and the creation of various supplemental forms, result in a notable change to the current form, related procedures will be released shortly. These procedures outline the proper use of the core document (MC 210); and provide an explanation on the use of each supplemental form, if needed, to gather further information at the face to face interview. Instructions on the use of these forms will also be discussed and reviewed at the training sessions.

#### **ORDERING**

As mentioned earlier in this letter, EMC2 No. 93105 asked counties to submit to the Medi-Cal Eligibility Branch (MEB) an estimated monthly usage amount, (2 month maximum), of the MC 210 and a projected amount for the supplementals. If your county did not place an order for the MC 210, a minimum of 100 or a camera ready copy will be shipped. (Smaller counties will receive 100 copies of the MC 210; larger counties will receive a camera ready copy.) Also, if your county did not place an order for the MC 210 supplementals or the MC 219 (formerly the cover sheet to the MC 210) from the MEB, you will need to order directly from the warehouse.

If you have any questions, please contact Leanna Pierson at (916) 654-0630 or Sherilyn Walden at (916) 657-3091.

Sincerely,

ORIGINAL SIGNED BY

Frank S. Martucci, Chief  
Medi-Cal Eligibility Branch

Enclosures

**READ THIS FIRST**  
**USE THESE INSTRUCTIONS TO HELP YOU FILL OUT**  
**THE ATTACHED MEDI-CAL STATEMENT OF FACTS**

1. Read the Statement of Citizenship, Alienage, and Immigration Status (MC 13) for important information regarding restricted benefits and alien status.
2. ***Print*** all answers in ink (black ink is best).

3. Please note the following:

**“Applicant”** means: a) you, if you are applying for yourself and you are an adult or a child applying for minor consent services; or, b) the person in long term care.

**“Caretaker”** means a relative other than a parent who is applying on behalf of children under 21 years. A caretaker may ask to be included in the children's Medi-Cal case.

**“Family Member”** means: a) you - even if you are a single person; b) your spouse or other parent of the children, living with you; c) your children under 21 years, who are living with you or are away at school; d) your spouse's or other parent's children under 21 years, who are living with you or are away at school; e) your unborn child.

4. If you answer **“Yes”** to any question from 23 through 39, you must give proof.
5. If you have a problem with any question, ***ask your worker for help.***
6. If you need more space to answer any question, ***use question 40.***

## STATEMENT OF FACTS (MEDI-CAL)

<b>ADDRESS (MEDI-CAL APPLICANT)</b>	① Home address      Number      Street      City      Zip Code					<b>COUNTY USE ONLY</b> Case Name: _____  Case No.: _____  Worker No.: _____  Date: _____						
	Mailing address (If different from above)											
	(Area Code) Home phone (   ) (   )		(Area Code) Work phone (   ) (   )		(Area Code) Message phone (   ) (   )	Person with whom to leave message:						
If any alien is asking for restricted Medi-Cal benefits, DO NOT fill in the shaded area below for Social Security Number.												
<b>ADULT FAMILY MEMBERS</b>	<b>LIST ADULTS HERE</b>							<b>COUNTY USE ONLY</b>				
	② Applicant or Caretaker's Name (First, Middle, Last)				Relationship to Applicant			Linkage	Chisem/Immig. MC 13	SEN	Preg	ID
	Social Security Number		Marital Status (check one) <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Common Law <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated (Date)		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female							
	Birthdate		Is the Person Blind or Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No		Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No		Medi-Cal Requested <input type="checkbox"/> Yes <input type="checkbox"/> No					
	③ Spouse/Other Parent (First, Middle, Last)				Relationship to Applicant			Linkage	Chisem/Immig. MC 13	SEN	Preg	ID
	Social Security Number		Marital Status (check one) <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Common Law <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated (Date)		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female							
	Birthdate		Is the Person Blind or Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No		Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No		Medi-Cal Requested <input type="checkbox"/> Yes <input type="checkbox"/> No					
	<b>LIST CHILDREN/UNBORN CHILDREN HERE</b>											
	④ Child's Name (First, Middle, Last) or "unborn"				Relationship to Applicant			Linkage	Chisem/Immig. MC 13	SEN	Preg	
	Social Security Number		In School <input type="checkbox"/> Yes <input type="checkbox"/> No		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Medical Support <input type="checkbox"/> YES <input type="checkbox"/> NO Not in home, 18 - 21 & tax dep.? CA 2.1 <input type="checkbox"/>					
Birthdate or date unborn is due		Is the Person Blind or Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No		Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No								
Father's Name		Is Either Parent (✓) <input type="checkbox"/> Deceased <input type="checkbox"/> Incapacitated <input type="checkbox"/> Absent <input type="checkbox"/> Unemployed										
Mother's Name		Child Living in Home <input type="checkbox"/> Yes <input type="checkbox"/> No		Medi-Cal Requested <input type="checkbox"/> Yes <input type="checkbox"/> No								
<b>CHILDREN</b>	⑤ Child's Name (First, Middle, Last) or "unborn"				Relationship to Applicant			Linkage	Chisem/Immig. MC 13	SEN	Preg	
	Social Security Number		In School <input type="checkbox"/> Yes <input type="checkbox"/> No		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Medical Support <input type="checkbox"/> YES <input type="checkbox"/> NO Not in home, 18 - 21 & tax dep.? CA 2.1 <input type="checkbox"/>					
	Birthdate or date unborn is due		Is the Person Blind or Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No		Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No							
	Father's Name		Is Either Parent (✓) <input type="checkbox"/> Deceased <input type="checkbox"/> Incapacitated <input type="checkbox"/> Absent <input type="checkbox"/> Unemployed									
	Mother's Name		Child Living in Home <input type="checkbox"/> Yes <input type="checkbox"/> No		Medi-Cal Requested <input type="checkbox"/> Yes <input type="checkbox"/> No							
	⑥ Child's Name (First, Middle, Last) or "unborn"				Relationship to Applicant			Linkage	Chisem/Immig. MC 13	SEN	Preg	
	Social Security Number		In School <input type="checkbox"/> Yes <input type="checkbox"/> No		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Medical Support <input type="checkbox"/> YES <input type="checkbox"/> NO Not in home, 18 - 21 & tax dep.? CA 2.1 <input type="checkbox"/>					
	Birthdate or date unborn is due		Is the Person Blind or Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No		Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No							
	Father's Name		Is Either Parent (✓) <input type="checkbox"/> Deceased <input type="checkbox"/> Incapacitated <input type="checkbox"/> Absent <input type="checkbox"/> Unemployed									
	Mother's Name		Child Living in Home <input type="checkbox"/> Yes <input type="checkbox"/> No		Medi-Cal Requested <input type="checkbox"/> Yes <input type="checkbox"/> No							
IF YOU HAVE MORE THAN 3 CHILDREN LIST HERE. LIST NAMES ONLY AND TELL YOUR WORKER: _____							<input type="checkbox"/> MC 210 8-C <input type="checkbox"/> Potential Spouse					

CHECK EACH ITEM YES OR NO		YES	NO	COUNTY USE
ARRANGEMENT	(7) Is there anyone living in your home that you did not list? ..... List Name(s): ..... .....			Relationship: <input type="checkbox"/> LTC return home in 6 mos? <input type="checkbox"/> MC 176 W.1 <input type="checkbox"/> Excess B & C Amount:
	(8) Is any family member living in a nursing home, hospital or board and care home? ..... Name of person: ..... Name of Home/Facility: ..... Date Entered: ..... Intend to return home? .....			
DEPENDENT	(9) Are you or any family member claimed as a tax dependent by a person not living with you? ..... Name and address of person claiming the tax deduction: ..... .....			<input type="checkbox"/> Tax dependent letter sent Date: ..... MC 21
RESIDENCE	(10) Do you or any family member have a home outside California? .....			Calif. Resident? <input type="checkbox"/> Yes <input type="checkbox"/> No
	(11) Are you or any family member living outside California? .....			
	(12) Do you and your family plan to stay in California? .....			
SITUATIONS	(13) Are you or any family member on strike? ..... List Name(s): .....			<input type="checkbox"/> Under 100 hours <input type="checkbox"/> If U-Parent MC 210 S-W <input type="checkbox"/> UIB Referral Redetermination: Fed Eligibility determined per MC 210 dated: .....
	(14) Are you, your spouse or the other parent in the home working? ..... List Name: ..... Hours Per Week: ..... List Name: ..... Hours Per Week: .....			
	(15) Are the person(s) in (14) looking for work or more hours of work? .....			
	(16) Have you, your spouse, other parent or any children worked in the last 2 years? ..... List Name(s): .....			
RETRO	(17) Did you or any family member get medical care or pregnancy care in the last three months? List Name(s): ..... .....			<input type="checkbox"/> MC 210A Retro: Mo. ____ Mo. ____ Mo. ____
DED. TPL	(18) Do you or any family member have a physical or emotional problem which makes it difficult to work or take care of personal needs? ..... List Name(s): .....			<input type="checkbox"/> DED Packet <input type="checkbox"/> Other Verif <input type="checkbox"/> CWC 6041
	(19) Was the physical or emotional problem caused by an injury or accident? .....			
PA OR OTHER PA	(20) Have you or any family member ever applied for or received assistance such as AFDC, Food Stamps, Medi-Cal, SSI/SSP, or other benefits? ..... List what kind: ..... List where received: ..... List when received: .....			<input type="checkbox"/> Pickle Screening: <input type="checkbox"/> SGA <input type="checkbox"/> Post MC <input type="checkbox"/> 30 + 1/3
MILITARY SERVICE	(21) Have you or any family member ever been in U.S. military service? ..... List Name(s): .....			<input type="checkbox"/> CA 5
	(22) Are you or any family member the spouse, parent, or child of a person who has been in U.S. military service? ..... List Name(s): .....			

Do you or any family member have any of the **PROPERTY/RESOURCES** listed below?

The county will determine whether or not the resources count.

- Include all resources owned, used, controlled, shared or held jointly with or for other person(s).
- Include resources on which you or a family member are named (even for convenience only).

**COUNTY USE**  
Obtain Verif. and  
enter nonexempt  
value \_\_\_\_\_  
☐ MC 210 S-P

		CHECK EACH ITEM "YES" OR "NO" →		YES	NO	WHOSE PROPERTY	VALUE	
LIQUID RESOURCES	23	Personal checking account? Enter how many accounts: _____						
		Bank name: _____ Account number: _____						\$ _____
		Saving or credit union account or trust fund? How many? _____						\$ _____
		Where: _____ Account number: _____						\$ _____
		IRA, KEOGH, deferred compensation, retirement account or annuity? _____						\$ _____
		Enter how many accounts: _____						\$ _____
		Cash or uncashed checks? _____						\$ _____
		Stocks, bonds, certificates of deposit or money market accounts? _____						\$ _____
REAL ESTATE	24	A home (whether you live in it or not)? _____						PR <input type="checkbox"/> YES <input type="checkbox"/> NO
		Other houses, land, buildings, mobile homes or life estates (in or outside the U.S.)? _____						\$ _____
		Mortgages, promissory notes, deeds of trust or sales contracts? _____						\$ _____
VEHICLES	25	Car, truck, motorcycle, trailer (any kind), off-road vehicles, airplanes, boats, campers (running or not)? _____						EXEMPT
		Enter how many vehicles owned: _____						<input type="checkbox"/> YES <input type="checkbox"/> NO
		Do you owe money on your vehicles? _____						\$ _____
OTHER	26	Have jewelry (not wedding/engagement or heirloom) worth more than \$100? _____						\$ _____
		If you are applying under Pickle, do you own household goods or personal items valued at more than \$500 per item (i.e. musical instrument)? _____						\$ _____ but, jointly owned <input type="checkbox"/> separately owned <input type="checkbox"/>
		Life insurance? Enter how many policies owned: _____						\$ _____
		Mineral rights or mining claims (oil, gas, coal, etc.)? _____						\$ _____
		Burial Trusts or contracts, insurance, money for burial or cemetery plots, caskets or other burial items? _____						\$ _____
		Enter how many: _____						\$ _____
		Other assets or resources? _____						\$ _____
BUSINESS	27	Business: checking/savings account or cash _____						\$ _____
		Business equipment, vehicles, tools, inventory or materials (including livestock or poultry not for personal use). _____ Type of Equipment: _____						\$ _____
TRANSFER	28	Has anyone given away, transferred, sold or traded any money, vehicles, property or other resources like those listed above in the last 30 months? If yes, complete the following:						LTC only:
		Item	Date	<input type="checkbox"/> Transferred <input type="checkbox"/> Sold				<input type="checkbox"/> Verification
				<input type="checkbox"/> Traded <input type="checkbox"/> Closed				<input type="checkbox"/> List Other Trans. in # 40
				<input type="checkbox"/> Given Away				
LIENS	29	Have you borrowed money against your property to pay medical bills? _____						Brings property within limits?
		Has a lien been put on any of your property as security for medical care? _____						<input type="checkbox"/> Yes <input type="checkbox"/> No
		Have you used any of the items above to pay for medical care? _____						If Yes <input type="checkbox"/> Notice to Provider
							Total Nonexempt Property minus current mo. income	\$ _____

**YES**

NO

**Amount  
Before  
Taxes**

## How Often

Use copy of a ward  
letter or check or other  
verification.

☐ Weekly (4.33)  
☐ Bi-Weekly (2.157)  
☐ Monthly  
☐ Twice Monthly  
☐ Actual  
☐ Other:

☐ Tax Statement  
☐ Profit/Loss

§

§ \_\_\_\_\_

§ \_\_\_\_\_

**\$** \_\_\_\_\_

§ \_\_\_\_\_

\$ \_\_\_\_\_

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§ \_\_\_\_\_

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**RESEARCH**

\_\_\_\_\_

1. *Chlorophyll a* (Chl *a*)

\_\_\_\_\_

1

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insurance, etc.

☐ Chart

**Abstract**

\_\_\_\_\_

☐ Sneeze

30 Money from a job? (including occasional work) \_\_\_\_\_  
If yes, how many people in your home work? \_\_\_\_\_  
Do you expect a change in your job? \_\_\_\_\_  
(More hours or more money) \_\_\_\_\_  
Explain: \_\_\_\_\_

(31) Self-employed income (includes businesses, baby sitting, out-of-home sales, swap meets, arts, crafts & income from crops or other farm income).

If yes, how many people are self-employed? \_\_\_\_\_

32	Social Security Benefits (Self)
	Social Security Benefits (Others)
	Social Security Benefits (Others)
	Cash Aid such as: SSL, AFDC, GR/GA or any other
	Child/Spousal Support or Alimony
	Money From Friends or Relatives
	Railroad Retirement
	Veteran's Benefits/Military Allotments
	Worker's Compensation

Unemployment Benefits (Self)

Unemployment Benefits (Others)

Disability or Sick Benefits

Pensions or Retirement

Scholarships, Loans, Grants

Interest Income or Dividends

Income From Rent or Contracts:  
(Including Room and Board)

Income from Training Program

Name of Program \_\_\_\_\_

Any Other Unearned Income: (including  
lottery/bingo winnings, lump sum payments)

**33) Receive Rent/Housing/Food (Room and Board):**  
If yes, check boxes:

	<b>Free</b>	<b>Work For</b>
Housing (Room and Board)	<input type="checkbox"/>	<input type="checkbox"/>
Utilities	<input type="checkbox"/>	<input type="checkbox"/>
Food	<input type="checkbox"/>	<input type="checkbox"/>
Clothing	<input type="checkbox"/>	<input type="checkbox"/>

OHC AND OTHER EXPENSES

ADDITIONAL INFORMATION

SEE THESE: YOUR ANSWERS TO THESE WILL NOT AFFECT YOUR ELIGIBILITY FOR MEDICAL

CHECK EACH ITEM "YES" OR "NO" <span style="font-size: small;">—————&gt;</span>	YES	NO	WHO PAYS	MONTHLY AMOUNT	COUNTY USE MC 210 S-W
34 Does the self-employed person have business expenses? .....					<input type="checkbox"/> Verification
35 Does anyone in your home pay child/spousal support, alimony or make other payments (medical, dental, etc.) for someone who does not live in the home?.....					<input type="checkbox"/> Court Order <input type="checkbox"/> Actual Payment \$ .....
36 Does anyone in your home pay someone to care for a child, a disabled or elderly adult so that a household member can work, attend training or school or look for work? List persons cared for:					<input type="checkbox"/> Dep. Care Receipts
37 Is anyone in your home a working disabled person who has medical expenses necessary to keep the job, such as wheelchair?					<input type="checkbox"/> Receipts
38 Is anyone paying college or educational costs? .....					\$ .....
39 Does anyone have health/medical insurance or Medicare? Who is insured? (List Names)  List Name of Insurance: .....					<input type="checkbox"/> QMB <input type="checkbox"/> Card <input type="checkbox"/> QDWI <input type="checkbox"/> SLMB <input type="checkbox"/> DHS 6155 <input type="checkbox"/> HIPP <input type="checkbox"/> EGHP OHC CODE: .....
Is health/medical insurance available through employment? .....					\$ .....
Has your health/medical insurance stopped in the last 60 days? .....					<input type="checkbox"/> SSA Referral
40 Additional Information: (List any additional information for Questions 1 through 39)  ..... ..... ..... .....					
41 A. Regular check-ups to help protect your family's health are available upon request through the Child Health and Disability Prevention Program (CHDP) for eligible members of your family under age 21.  • Do you want more information about CHDP Services? .....	YES	NO	COUNTY USE		
• Do you want CHDP medical or dental services? .....					
B. If you are pregnant, you can get help finding a doctor, getting transportation to see the doctor, and other help. Do you want to talk to someone about this help? .....			<input type="checkbox"/> CHDP Brochure and Explanation Given Date: .....		
C. Are you breastfeeding a child?..... Have you given birth within the last three months?.....			<input type="checkbox"/> Referral		
• If you answered "YES" to either of these questions, you may be eligible for services provided by the Special Supplemental Food Program for Women, Infants and Children (WIC)			<input type="checkbox"/> WIC referral		
D. Do you want information about Family Planning Services?.....			<input type="checkbox"/> Pregnant <input type="checkbox"/> Parent or Guardian of child under 5		
E. Do you want to talk to a social worker about other services which may be available to you? .....			<input type="checkbox"/> Breastfeeding <input type="checkbox"/> Postpartum		
• If "Yes," briefly describe:			<input type="checkbox"/> Family Planning Information Given <input type="checkbox"/> Referred Date: .....		
			<input type="checkbox"/> Social Services Referral		



# CERTIFICATION

I have read and received a copy of the MC 219.

- I am aware of, understand, and agree to meet all my responsibilities as described on the MC 219.
- I understand that all of the statements, including benefit and income information, that I have made on this form are subject to investigation and verification.
- I understand that Section 1137 of the Social Security Act requires that I provide Social Security numbers (SSNs) for myself and any family members if I/we request full Medi-Cal benefits. I understand that my/our SSNs will be verified and will be used in a computer match to check the income and resources I/we report with information from welfare, state employment, income tax, Social Security Administration, and other agencies. I understand that this is done to make sure that my/our family's eligibility and share-of-cost level, if any, are correct.

I declare under penalty of perjury under the laws of the United States of America and the State of California that the information contained in this Statement of Facts is true and correct.

Signature of Applicant	Date
Signature of Witness (If applicant signed with a mark)	Date
Signature of person helping applicant fill out the form	Date

It is the responsibility of the beneficiary and person acting for the applicant/recipient to report to the Eligibility Worker within ten (10) days any changes that occur.

Signature of Person Acting for Applicant/Beneficiary	Date
Address of Person Acting for Applicant/Beneficiary	Phone Number of Person Acting for Applicant

## COUNTY USE ONLY

Supplemental Forms Issued	Client Initial	Date
EW Signature	Worker Number	Date

**ADDITIONAL CHILDREN****(SUPPLEMENT TO THE MEDI-CAL STATEMENT OF FACTS - MC 210)****IF YOU HAVE MORE THAN THREE CHILDREN, LIST HERE AND GIVE THIS FORM TO YOUR WORKER****If any alien is asking for Restricted Medi-Cal benefits, DO NOT fill in the shaded area below for Social Security Number.****COUNTY USE ONLY**

Case Name: \_\_\_\_\_

Case No.: \_\_\_\_\_

Worker No.: \_\_\_\_\_

Date: \_\_\_\_\_

(A) Child's Name (First, Middle, Last) or "unborn"		Relationship to Applicant	Linkage	Citizen/ Immig. MC 13	SSN	Preg
Social Security Number	In School <input type="checkbox"/> Yes <input type="checkbox"/> No	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female				
Birthdate or date unborn is due	Is the Person Blind or Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No				
Father's Name	Is Either Parent (✓) <input type="checkbox"/> Deceased <input type="checkbox"/> Incapacitated <input type="checkbox"/> Absent <input type="checkbox"/> Unemployed	Medical Support <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> CA 2.1 <input type="checkbox"/> Not in home, 18 - 21 & tax dep.?				
Mother's Name	Child Living in Home <input type="checkbox"/> Yes <input type="checkbox"/> No	Medi-Cal Requested <input type="checkbox"/> Yes <input type="checkbox"/> No				
(B) Child's Name (First, Middle, Last) or "unborn"		Relationship to Applicant	Linkage	Citizen/ Immig. MC 13	SSN	Preg
Social Security Number	In School <input type="checkbox"/> Yes <input type="checkbox"/> No	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female				
Birthdate or date unborn is due	Is the Person Blind or Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No				
Father's Name	Is Either Parent (✓) <input type="checkbox"/> Deceased <input type="checkbox"/> Incapacitated <input type="checkbox"/> Absent <input type="checkbox"/> Unemployed	Medical Support <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> CA 2.1 <input type="checkbox"/> Not in home, 18 - 21 & tax dep.?				
Mother's Name	Child Living in Home <input type="checkbox"/> Yes <input type="checkbox"/> No	Medi-Cal Requested <input type="checkbox"/> Yes <input type="checkbox"/> No				
(C) Child's Name (First, Middle, Last) or "unborn"		Relationship to Applicant	Linkage	Citizen/ Immig. MC 13	SSN	Preg
Social Security Number	In School <input type="checkbox"/> Yes <input type="checkbox"/> No	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female				
Birthdate or date unborn is due	Is the Person Blind or Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No				
Father's Name	Is Either Parent (✓) <input type="checkbox"/> Deceased <input type="checkbox"/> Incapacitated <input type="checkbox"/> Absent <input type="checkbox"/> Unemployed	Medical Support <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> CA 2.1 <input type="checkbox"/> Not in home, 18 - 21 & tax dep.?				
Mother's Name	Child Living in Home <input type="checkbox"/> Yes <input type="checkbox"/> No	Medi-Cal Requested <input type="checkbox"/> Yes <input type="checkbox"/> No				
(D) Child's Name (First, Middle, Last) or "unborn"		Relationship to Applicant	Linkage	Citizen/ Immig. MC 13	SSN	Preg
Social Security Number	In School <input type="checkbox"/> Yes <input type="checkbox"/> No	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female				
Birthdate or date unborn is due	Is the Person Blind or Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No				
Father's Name	Is Either Parent (✓) <input type="checkbox"/> Deceased <input type="checkbox"/> Incapacitated <input type="checkbox"/> Absent <input type="checkbox"/> Unemployed	Medical Support <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> CA 2.1 <input type="checkbox"/> Not in home, 18 - 21 & tax dep.?				
Mother's Name	Child Living in Home <input type="checkbox"/> Yes <input type="checkbox"/> No	Medi-Cal Requested <input type="checkbox"/> Yes <input type="checkbox"/> No				
(E) Child's Name (First, Middle, Last) or "unborn"		Relationship to Applicant	Linkage	Citizen/ Immig. MC 13	SSN	Preg
Social Security Number	In School <input type="checkbox"/> Yes <input type="checkbox"/> No	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female				
Birthdate or date unborn is due	Is the Person Blind or Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No				
Father's Name	Is Either Parent (✓) <input type="checkbox"/> Deceased <input type="checkbox"/> Incapacitated <input type="checkbox"/> Absent <input type="checkbox"/> Unemployed	Medical Support <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> CA 2.1 <input type="checkbox"/> Not in home, 18 - 21 & tax dep.?				
Mother's Name	Child Living in Home <input type="checkbox"/> Yes <input type="checkbox"/> No	Medi-Cal Requested <input type="checkbox"/> Yes <input type="checkbox"/> No				
(F) Child's Name (First, Middle, Last) or "unborn"		Relationship to Applicant	Linkage	Citizen/ Immig. MC 13	SSN	Preg
Social Security Number	In School <input type="checkbox"/> Yes <input type="checkbox"/> No	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female				
Birthdate or date unborn is due	Is the Person Blind or Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No				
Father's Name	Is Either Parent (✓) <input type="checkbox"/> Deceased <input type="checkbox"/> Incapacitated <input type="checkbox"/> Absent <input type="checkbox"/> Unemployed	Medical Support <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> CA 2.1				
Mother's Name	Child Living in Home <input type="checkbox"/> Yes <input type="checkbox"/> No	Medi-Cal Requested <input type="checkbox"/> Yes <input type="checkbox"/> No				

**VOCATIONAL AND WORK HISTORY**

NAME: \_\_\_\_\_ CASE NAME: \_\_\_\_\_

CASE NUMBER: \_\_\_\_\_ WORKER NO. \_\_\_\_\_ PERSON NO. \_\_\_\_\_ DATE: \_\_\_\_\_

A. Have you worked, quit a Job, or refused a job or training within the last 30 days? ☐ Yes ☐ No

Name and Address of Employer/Training	Last day of Job/Training Month      Day      Year	Amount of last Paycheck \$
Hours of Work/Training in last 30 days	Reason for Leaving or Refusal	

B. Are you actively seeking work.? ☐ Yes ☐ NoC. Have you received Unemployment Insurance Benefits (UIB) within the last 12 months? ☐ Yes ☐ NoD. Do you earn any other money, such as tips, commissions, overtime, shift differential, etc. ☐ Yes ☐ No

If "Yes", how much? \$ \_\_\_\_\_ Days worked per week: \_\_\_\_\_ Hours per week: \_\_\_\_\_

E. List your employment and training history for the last 5 years. Begin with last job or training.

Name of Employer or Training Program	Work or Training	When Employed (Mo/Day/Year)	Amount Paid Monthly	Name of Employer or Training Program	Work or Training	When Employed (Mo/Day/Year)	Amount Paid Monthly
1.	<input type="checkbox"/> Work <input type="checkbox"/> Training	From / / To / /	\$	4.	<input type="checkbox"/> Work <input type="checkbox"/> Training	From / / To / /	\$
2.	<input type="checkbox"/> Work <input type="checkbox"/> Training	From / / To / /	\$	5.	<input type="checkbox"/> Work <input type="checkbox"/> Training	From / / To / /	\$
3.	<input type="checkbox"/> Work <input type="checkbox"/> Training	From / / To / /	\$	6.	<input type="checkbox"/> Work <input type="checkbox"/> Training	From / / To / /	\$

I understand that the statements I have made on this form are subject to investigation and verification. "I declare under penalty of perjury that the foregoing statements are true and correct."

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Person No. 2 - Name: \_\_\_\_\_

A. Have you worked, quit a Job, or refused a job or training within the last 30 days? ☐ Yes ☐ No

Name and Address of Employer/Training	Last day of Job/Training Month      Day      Year	Amount of last Paycheck \$
Hours of Work/Training in last 30 days	Reason for Leaving or Refusal	

B. Are you actively seeking work.? ☐ Yes ☐ NoC. Have you received Unemployment Insurance Benefits (UIB) within the last 12 months? ☐ Yes ☐ NoD. Do you earn any other money, such as tips, commissions, overtime, shift differential, etc. ☐ Yes ☐ No

If "Yes", how much? \$ \_\_\_\_\_ Days worked per week: \_\_\_\_\_ Hours per week: \_\_\_\_\_

E. List your employment and training history for the last 5 years. Begin with last job or training.

Name of Employer or Training Program	Work or Training	When Employed (Mo/Day/Year)	Amount Paid Monthly	Name of Employer or Training Program	Work or Training	When Employed (Mo/Day/Year)	Amount Paid Monthly
1.	<input type="checkbox"/> Work <input type="checkbox"/> Training	From / / To / /	\$	4.	<input type="checkbox"/> Work <input type="checkbox"/> Training	From / / To / /	\$
2.	<input type="checkbox"/> Work <input type="checkbox"/> Training	From / / To / /	\$	5.	<input type="checkbox"/> Work <input type="checkbox"/> Training	From / / To / /	\$
3.	<input type="checkbox"/> Work <input type="checkbox"/> Training	From / / To / /	\$	6.	<input type="checkbox"/> Work <input type="checkbox"/> Training	From / / To / /	\$

I understand that the statements I have made on this form are subject to investigation and verification. "I declare under penalty of perjury that the foregoing statements are true and correct."

# EMPLOYMENT INFORMATION CONTINUED

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

Person Number: \_\_\_\_\_ Date Employment began: \_\_\_\_/\_\_\_\_/\_\_\_\_ Work Hours: from \_\_\_\_ to \_\_\_\_

Occupation/Job Title: \_\_\_\_\_

Address: \_\_\_\_\_ Work phone #: (\_\_\_\_) \_\_\_\_\_

Type of income (Example: Child support, grants/loans, UIB, lottery, rental, etc.)


If your income changes from month to month, show your actual income for the current month in "Month 1" below, and your estimated gross income for the following two months in "Month 2" and "Month 3".

Name and Occupation	Month 1	Month 2	Month 3
	\$	\$	\$
	\$	\$	\$

If self-employed, complete the following: Adjusted gross income from last federal tax return: \$ \_\_\_\_\_

Has income changed? ☐ Yes ☐ No

If income has changed or no tax return, what was:

Changed Income	Amount	Changed Income	Amount
Gross profit per year or cash payment from self-employment	\$	Business checking account:	\$
Business expenses per year (Example: Salaries to employee's equipment):	\$	Average monthly cash expenditures:	\$
Cash on hand for business:	\$	Average monthly cash drawn from business:	\$

Do you or any family member pay child support or alimony under a court order or based on an agreement with the District Attorney? ☐ Yes ☐ No

If "Yes", please complete the following:

Monthly Amount Paid	By whom	Date last paid	To whom
\$		/ /	

Does anyone who works pay for care of a child or disabled adult? ☐ Yes ☐ No

If "Yes", please complete the following:

	Person 1	Person 2	Person 3
Name of person receiving care			
Age of person receiving care			
Amount of payment and how often paid	\$ _____ every <input type="checkbox"/> day <input type="checkbox"/> week <input type="checkbox"/> month	\$ _____ every <input type="checkbox"/> day <input type="checkbox"/> week <input type="checkbox"/> month	\$ _____ every <input type="checkbox"/> day <input type="checkbox"/> week <input type="checkbox"/> month

Who do you pay for the care: Name \_\_\_\_\_ Address \_\_\_\_\_

Is there a non-working member of the family (parent, sister/brother of child, spouse or child of an incapacitated adult) living in the home? ☐ Yes ☐ No

Is that person able to take care of the child or incapacitated adult? ☐ Yes ☐ No

If you are a working disabled person, do you have any medically-related expenses which are necessary for your employment, such as a wheelchair, etc.? ☐ Yes ☐ No

If "Yes", list below:

Type of Expense	Amount
	\$

## COUNTY USE ONLY

### VERIFICATION (List):

- ☐ Wage stubs
- ☐ Tips
- ☐ Child in school
- ☐ Exempt earnings

### Conversion Factor:

- ☐ Actual
- ☐ 4.33
- ☐ 2.167

## COURT ORDER

Amount \$ \_\_\_\_\_

- ☐ Verification of payment
- ☐ Other person in MFBU who could provide care
- ☐ Verification amount paid and age of person receiving care

☐ IRWE (OMB only)

**MEDI-CAL U-PARENT DETERMINATION WORKSHEET**

NOTE: DETERMINE THE CONNECTION WITH THE LABOR FORCE FOR THE P.W.E. ONLY.

## I. Determination of Primary Wage Earner (P.W.E.)

Intake:

- a. Application date
- OR
- date U-Parent deprivation began.

Enter MO/YR \_\_\_\_\_

- b. Month #1 - Subtract 2 years from line A. (Circle MO on chart) \_\_\_\_\_

- c. Month #24 - MO/YR immediately preceeding line A \_\_\_\_\_

(Circle MO on chart)

CURRENT YEAR 19 \_\_\_\_\_ YEAR 19 \_\_\_\_\_ YEAR 19 \_\_\_\_\_

Name	DEC	NOV	OCT	SEP	AUG	JUL	JUN	MAY	APR	MAR	FEB	JAN	DEC	NOV	OCT	SEP	AUG	JUL	JUN	MAY	APR	MAR	FEB	JAN	Total
Father:																									
Mother:																									

## II. Enter complete total earnings for 24 month period on the above chart. Person earning greater amount is P.W.E.

NAME \_\_\_\_\_

1. The P.W.E. meets the definition of Unemployed-parent by either:

☐ NOT WORKINGOR☐ WORKING LESS THAN 100 HOURS A MONTH FOR MORE THAN 30 DAYS ☐ YES ☐ NO

2. The P.W.E. has not refused an offer of employment or employment-related training or quit a job or employment training program within 30 days, without good cause.

☐ YES (Has not  
quit/refused w/o  
good cause)  
☐ NO

3. The P.W.E. has applied for and accepted UIB to which entitled.

☐ YES ☐ NO

4. The AFDC-U parent has established a connection with the labor force by either:

A. ☐ Receiving, or being eligible to receive, UIB within one year before application for aid.

OR

B. ☐ Having 6 eligible quarters out of any 13 consecutive quarters in the last ☐ YES ☐ NO  
17 calendar quarters before date of application for aid. (Complete Below)

**STEP ONE:** Beginning with year of application, enter 5 consecutive years.

**STEP TWO:** Enter # 1 in the quarter within which the application date falls.

**STEP THREE:** Beginning with quarter # 1, number each quarter, left to right, through quarter # 17.

**STEP FOUR:** From the CWD 282, check eligible quarters.

An eligible quarter is: 1) Earning at least \$50 gross in a quarter OR  
2) Participating at least 5 days in an approved training program.

**STEP FIVE:** Count checkmarks in each 13 consecutive quarter grouping until the 6 eligible quarters criteria is met.

YR.	19____ (Current Year)				19____				19____				19____				19____			
QTR.	OCT- DEC	JULY- SEPT	APR- JUNE	JAN- MAR	OCT- DEC	JULY- SEPT	APR- JUNE	JAN- MAR	OCT- DEC	JULY- SEPT	APR- JUNE	JAN- MAR	OCT- DEC	JULY- SEPT	APR- JUNE	JAN- MAR	OCT- DEC	JULY- SEPT	APR- JUNE	JAN- MAR
\$50																				
TRNG																				

How many checkmarks? Quarter Grouping: 1 thru 13 \_\_\_\_; 2 thru 14 \_\_\_\_; 3 thru 15 \_\_\_\_; 4 thru 16 \_\_\_\_; 5 thru 17 \_\_\_\_

5. The P.W.E. is unemployed for reasons other than participation in a labor dispute. (Strike)

☐ YES ☐ NO

6. ARE QUESTIONS 1 THROUGH 6 ALL ANSWERED YES?

☐ YES ☐ NO

IF NUMBER 6 IS ANSWERED YES, THE CASE IS AFDC-MN LINKED.

IF NUMBER 6 IS ANSWERED NO, THE ENTIRE MFBU IS MI, UNLESS DEPRIVATION EXISTS.

**INCOME IN-KIND/HOUSING VERIFICATION**

(SUPPLEMENT TO THE MC 210 STATEMENT OF FACTS)

WE NEED THE FOLLOWING INFORMATION TO DETERMINE THE VALUE OF THE HOUSING/RENT, UTILITIES, FOOD OR CLOTHING THAT YOU ARE RECEIVING FREE OR IN EXCHANGE FOR WORK.

**County Use Box**

Case Name: \_\_\_\_\_

Case No.: \_\_\_\_\_

Worker No.: \_\_\_\_\_ Date: \_\_\_\_\_

**Part I.****IN-KIND INCOME VERIFICATION****A. Applicant Authorization Section: (Sign this section if you want the county to verify IN-KIND INCOME)**

Name(s): \_\_\_\_\_

Address: \_\_\_\_\_

*I hereby authorize \_\_\_\_\_ county to contact \_\_\_\_\_ concerning any of the information requested below.*

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**B. Provider Statement Section: (Statement of person giving/sharing housing, utilities, food, clothing, etc.)**

1. The person(s) named above receives from me/my family:

☐ Housing/Rent    ☐ Utilities    ☐ Food    ☐ Clothing    ☐ Cash
• This is ☐ Free    ☐ In exchange for \_\_\_\_\_

• I/We have been providing these items since \_\_\_\_\_

• I/We expect to continue to provide these items until \_\_\_\_\_

2. I/We share household expenses with the person(s) named above.    ☐ Yes    ☐ No

(If no, go to number 3.)

Our shared arrangement is: \_\_\_\_\_

3. The TOTAL cost of household items at the above address is:

Housing \_\_\_\_\_ Rent \_\_\_\_\_ Utilities \_\_\_\_\_ Food \_\_\_\_\_ Clothing \_\_\_\_\_ Cash: \_\_\_\_\_

• The number of people in the household at the above address is: \_\_\_\_\_

4. My relationship to the person(s) named above is: \_\_\_\_\_

**I CERTIFY THAT THE INFORMATION IN THIS SECTION IS TRUE AND CORRECT:**

Provider Signature \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

**Part II.****HOUSING VERIFICATION**

SIGN BELOW ONLY IF YOU, THE APPLICANT, WANT TO PROVIDE INFORMATION ABOUT FREE HOUSING OR RENT PAID TO A RELATIVE AS EVIDENCE OF RESIDENCY. BEFORE YOU SIGN, YOU MUST FILL IN THE HOUSING INFORMATION REQUESTED ABOVE.

I understand that the information I provide as evidence of residency may be verified by county or state employees processing my application. I agree to cooperate with any such employee in the verification of this information. I hereby authorize any county or state employee responsible for administering the Medi-Cal program to contact \_\_\_\_\_ concerning any of the information provided above.

**I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE INFORMATION CONTAINED IN THIS STATEMENT IS TRUE, CORRECT, AND COMPLETE.**

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Student Educational Expenses

**Supplement to the Medi-Cal Statement of Facts - MC 210)**

**COUNTY USE ONLY**

**Case Name:** \_\_\_\_\_

Case No.: \_\_\_\_\_

**Worker No.** \_\_\_\_\_

Date: \_\_\_\_\_

**If you or any family member are in college or attending a similar educational institution, please fill in the following:**

See MEM 50447 for allowable education expenses.

**EXEMPT:**

☐ Entire amount☐ Only expenses

**VERIFICATION (List):**

Transportation costs allowed  
(show computations):

A. Student's name(s):

Name of institution(s):

**Status of student(s):**

☐ Full-time    ☐ Part-time☐ Grad      ☐ Undergrad☐ Full-time    ☐ Part-time☐ Grad      ☐ Undergrad

**B. Grants, Loans, Scholarships, Fellowships:**

**Amount received:**

Source(s) of grants, loans, etc.:

**How often received?**

**C. Expenses Per Term:**

**Is term a semester, quarter, year?**

**Tuition/fees:**

**Books, equipment, and supplies:**

**Child care necessary for school:**

D. Transportation to School/Child Care:

**Round trip miles per day:**

**School attended how many days per week:**

Type of transportation used (own car, borrowed car, car pool, bus, etc.):

**Costs (per month):**

● Amount paid by student (not own car)

● Amount paid by riders

- Parking, tolls, etc.

Is public transportation (bus, train, etc.) available?

☐ Yes      ☐ No☐ Yes      ☐ No

● If yes, indicate cost:



# Property/Resources

## (Supplement to the Medi-Cal Statement of Facts - MC 210)

Please fill in the following, if you answered "YES" to certain Property/Resource questions from the Statement of Facts MC 210.

①	Fill in the following if more room was needed to list liquid resources ( Checking/Savings/IRA'S, Stocks, etc.)	COUNTY USE ONLY																				
<b>LIQUID RESOURCES</b>	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 20%;">Type of Resource</th> <th style="width: 20%;">Owner of Resource</th> <th style="width: 10%;">Account Number</th> <th style="width: 30%;">Name and Address</th> <th style="width: 20%;">Current Value</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td style="text-align: right;">\$</td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td style="text-align: right;">\$</td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td style="text-align: right;">\$</td> </tr> </tbody> </table>	Type of Resource	Owner of Resource	Account Number	Name and Address	Current Value					\$					\$					\$	Case Name: _____ _____ Case No.: _____ Worker No.: _____ Date: _____
	Type of Resource	Owner of Resource	Account Number	Name and Address	Current Value																	
					\$																	
					\$																	
				\$																		
<b>REAL ESTATE</b>	A. If you or any family member answered "YES" to owning or buying any of the items listed under the Real Estate part of the MC 210, fill in the following. List any property in any state or country and all land you own, have title to, or share title in. ITEMS: Houses, lots, land, apartments, mobile homes taxed as real property, or other.																					
	Address or Legal Description of Property: _____ _____ Name of Owner: _____ Does anyone live there now? <input type="checkbox"/> Yes <input type="checkbox"/> No      How long have they lived there? _____ Name of person living there: _____ Relationship to you: _____ Do you plan to return to that property to live? <input type="checkbox"/> Yes <input type="checkbox"/> No (You must notify the county within ten (10) days of any change in plans for living at the property.) Is the property currently listed for sale? <input type="checkbox"/> Yes <input type="checkbox"/> No Full value of property (from tax statement): \$ _____ Amount owed: \$ _____ Rent collected each month from property: \$ _____ Expenses on property: • Interest \$ _____ Yearly/Monthly      • Insurance \$ _____ Yearly/Monthly • Taxes and Assessments \$ _____ Yearly/Monthly      • Upkeep and Repairs \$ _____ Yearly/Monthly • Utilities \$ _____ Yearly/Monthly																					
B. If you or any family member answered "YES" to the life estate property question, please fill in the address of the property below. Address: _____ _____ _____ Do you or any family member have an income interest in a life estate? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the life estate (producing/earning/providing/giving) income? <input type="checkbox"/> Yes <input type="checkbox"/> No																						

Verification of "Good Cause" for Nonutilization of Property

Verification of Income and Expenses (List):

53

6.

List exempt vehicle:

☐ Verification of nonexempt vehicles

☐ Verification of encumbrance

List exempt vehicle:

☐ Verification of nonexempt vehicles

☐ Verification of encumbrance

☐ Verification of personal property

☐ Verification of personal property

10

If you or any family member answered "YES" to owning items in the **OTHER** or **BUSINESS** section of the Statement of Facts, MC 210, please give more detailed information about those items here.

④

**A.** If you or any family member own items of jewelry valued at more than \$100 each, or are applying under Pickle and your items are over \$500, you must fill in the following :  
(Do not include wedding, engagement rings, or heirlooms.)

Description	Listed for Sale?		Amount Owed
	Yes	No	
			\$
			\$

**B.** If you or any family member answered "YES" to owning life insurance, you must fill in the following:

Insurance Company	Person Insured	Face Value	Policy Number	Date Policy Issued	Current Cash Value
	Policy Owned By				
1.		\$			\$
2.		\$			\$
3.		\$			\$

**C.** If you or your family member answered "YES" to owning one or more of the following:

1. burial plot, vault, or crypt, is it for use of immediate family? ☐ Yes ☐ No  
or 2. mineral rights or mining claims, is either listed for sale? ☐ Yes ☐ No

Please give more detailed information:

Description: \_\_\_\_\_

Owned by: \_\_\_\_\_

Current Value: \$ \_\_\_\_\_ Amount Owed: \$ \_\_\_\_\_

Location: \_\_\_\_\_

**D.** If you or your family member answered "YES" to owning a burial reserve or trust, please fill in the following:

Purchase Price	Amount Owed	Purchased	
		For Whom	From Whom
\$	\$		
\$	\$		
\$	\$		

- ☐ Revocable  
☐ Irrevocable  
☐ Designated Funds

Current Value \$ \_\_\_\_\_

OTHER

⑤

If you or any family member answered "YES" to owning one or more of the following types of business items: equipment, vehicles, tools, inventory or materials (including livestock or poultry not for personal use), you must give more detailed information by filling in the following.

Description of Item	Estimated Value	Amount Owed
	\$	\$
	\$	\$
	\$	\$

BUSINESS

**COUNTY USE ONLY**

Heirloom? \_\_\_\_\_

Total Nonexempt \_\_\_\_\_

Appraised Value \$ \_\_\_\_\_

☐ Exempt

Yes No CSV

Exempt ☐ ☐ \$ \_\_\_\_\_

Exempt ☐ ☐ \$ \_\_\_\_\_

Exempt ☐ ☐ \$ \_\_\_\_\_

Total CSV \$ \_\_\_\_\_

Exempt ☐ ☐ \$ \_\_\_\_\_